Testimony
of
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Hearing on S. 1770 to Elevate the position of Director of
the Indian Health Service to
Assistant Secretary for Indian Health

Before the
Senate Committee on Indian Affairs
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Good Morning,

It is an honor to be invited here today to provide testimony on Senate Bill 1770 to elevate the Director of the Indian Health Service to an Assistant Secretary for Indian Health.

My name is Julia Davis. I am a member of the Nez Perce Tribal Council and the Portland Area delegate to the National Indian Health Bard. I am here today in my role as Chair of the Northwest Portland Area Indian Health Board, a tribal organization which represents 40 Federally-recognized tribes from Idaho, Oregon and Washington on health-related issues.

The Northwest Portland Area Indian Health Board has formally supported the elevation of the Director of the Indian Health. Service (IHS) to an Assistant Secretary since 1996, Northwest tribes are committed to this for many reasons, but first and foremost, we see this as recognition of the special and unique relationship between the 546 Federally-recognized Indian tribes and the U.S. government. In 1976, Congress declared'.it the policy of the nation in fulfillment of its special responsibilities and legal obligations to the American Indian people to assure the highest possible health status for Indians. We believe this legislation will help make that policy a reality.

The Department of Interior recognized the special status of Indian people when in 1977 it elevated the Director of the Bureau of Indian Affairs to an Assistant Secretary. It is time for comparable recognition to be given to the individual responsible for health care delivery to over a million American Indian and Alaska Native people. While Indian Self-Determination and the recognition of a government-to-government relationship has been the policy of every Administration since President Nixon, within the Department of Health and Human Services (HHS), decision makers have not always understood the implications of this uniqueness and the commitment to this special responsibility.

Let me provide just two recent examples where this has been the case. In 1994, HHS through the Health Care Financing Administration approved waivers to State Medicaid plans for both Oregon and Washington. These waivers allowed the states to require Medicaid patients to enroll in private-sector managed care health plans. Neither HCFA nor. the states consulted with IHS or

tribes to determine the impact this would have on Indian people or Indian health programs-programs that depend on Medicaid collections for 20-40% of their clinic operating budgets. Indian health programs were simply overlooked. It was only when tribes read in newspapers what was happening and began asking questions of both IHS and the states that a dialogue began. It was the initiative of tribes that insured that the rights of Indian patients to go to Indian health clinics and the rights of Indian health programs to bill for services provided to Medicaid-eligible patients were protected. Had an Assistant Secretary for Indian Health been at the table when Department-level discussions of Medicaid reform took place, the impact on Indian Health programs and Indian people would have been foreseen and a great deal of time, money and effort saved. While in Oregon, Washington and Idaho tribes have worked closely with states to resolve issues, we know that in other states Medicaid reform continues to create significant hardship and difficulties for Indian health programs and Indian people.

Our second example is the Administration's current initiative to reduce the racial disparity in health status. At the same time that the Department was announcing this initiative to the nation, it was proposing to Congress a budget for the Indian Health Service for Fiscal Year 1999 that would increase this disparity for Indian people. While requesting three to fifteen percent increases for other agencies, HHS proposed no increase for IHS. HHS did not request funds for IHS for mandatory cost increases for medical and general inflation, for pay act increases, or for population growth. Adding insult to injury, the initiatives proposed to address racial disparity for Indian people were to be paid for by cutting funding from the operating budgets of Indian health clinics. Having an Assistant Secretary for Indian Health at the table when decisions were made on both the disparity initiative and the FY 99 Department Budget could well have resulted in the Department understanding and addressing the needs Indian people.

These are but two examples of Department activity we have experienced over the years that has led our organization to view it as critical to have an. advocate for Indian health at the highest levels of the Department.

IHS is strikingly different in a Department that primarily awards money to states, universities, or research organizations to carry out programs and projects. IHS is in the business of delivering direct health care either through Federally-operated or tribally-operated programs. Someone knowledgeable of the Indian health care system must be at the table: when key decision making-is taking place to advance the needs of AI/ANs and to protect Indian health care from inadvertent harm. This is true not only when the discussion is the directly about the Indian Health Service, but in the discussion of many Department-wide policies and initiatives. This is certainly a lesson we learned from Medicaid reform. Consequently, we are very supportive of the proposed legislative language which calls for an Assistant Secretary of Indian Health and not just of the Indian Health Service.

Certainly there are other simply factual reasons which justify the elevation. IHS has over 14,000 FTEs and employs forty percent of the Nation's Commissioned Corp Officers. The IHS budget exceeds that of the Bureau of Indian Affairs by over half a billion dollars and an Assistant Secretary leads the Bureau. The elevation is supported by tribes as reflected by the resolutions from the Northwest Portland Area Indian Health Board, the National Indian Health Board, the

National Congress of American Indians, and many other Indian organizations.

The Northwest Portland Area Indian Health Board supports S. 1770 and is committed to its passage. We support the intent of the legislation to give the position a broad scope of influence within the Department by proposing an Assistant Secretary for Indian Health, We believe the new Assistant Secretary should lead an agency independent of the Public Health Service and maintain continued access to and authority over members of the Commissioned Corp who chose to work in the Indian Health system. These health care providers are critical to health care delivery in rural, isolated parts of Indian country.

Some may ask if creating a new assistant secretary is prudent while Congress is limiting government spending. When answering that, question NPAIHB hopes Congress will consider the over one billion dollars IHS has contributed since 1995 to balancing the Federal budget as a result of unfunded mandatory cost increases. Any additional costs should require a budget transfer from those agencies in the Department whose workload will be reduced.

Once again, thank you for the opportunity to speak today and for the leadership of this Committee in addressing the health care needs of Indian people.